IN THE MATTER OF AN INTEREST ARBITRATION PURSUANT TO

THE HOSPITAL LABOUR DISPUTES ARBITRATION ACT

BETWEEN:

The Participating Hospitals

and

ONA

Before:	William Kaplan, Chair Brian O'Byrne, OHA Nominee Kate Hughes, Association Nominee
Appearances	
For the OHA:	Sunil Kapur McCarthys Barristers & Solicitors
For ONA:	Beverly Mathers Senior Director, Labour Relations ONA

The matters in dispute proceeded to a hearing on February 26 & 27, 2018. The Board met in Executive Session on March 14, 2018 and June 26, 2018.

Introduction

This Board of Interest Arbitration was consensually convened to settle the terms and conditions of the central collective agreement between the Ontario Nurses' Association (hereafter "the Association") and the Ontario Hospital Association (hereafter "the OHA"). The Association represents 61,000 Registered nurses and allied health professionals working in 134 participating hospitals. This is the 17th round of central bargaining between these parties.

The Association and the OHA agreed upon the terms for central bargaining and memorialized those terms in the Memorandum of Conditions for Joint Bargaining signed on October 17, 2017 (and revised on January 27, 2018). The parties met in negotiations between January 22 and 31, 2018. Mediation followed between February 1 and 3, 2018. It is fair to say that the parties were unable to resolve any of the major items in dispute, although agreement was reached on some issues. When the mediation proved unsuccessful, the issues in dispute proceeded to a hearing, and that arbitration took place in Toronto on February 26 & 27, 2018. The Board met in Executive Session in Toronto on March 14, 2018 and June 26, 2018.

In deciding the outstanding issues, the Board has paid careful attention to the statutory and other criteria that govern the adjudication of disputes of this kind, most particularly replication: replication of free collective bargaining. That issue, and it is one that also engaged the identification of the appropriate comparator, was hotly contested by the parties. Indeed, both parties made detailed presentations and also filed written briefs and other documents in support of their positions. It is fair to say – as is illustrated by the nominees' dissents – that there is absolutely no common ground between the parties.

For its part, the Association takes the position that ONA has always zealously pursued its own bargaining objectives and has no central hospital comparator – it bargains for itself. ONA primarily but not exclusively submits that nurse settlements are the primary, appropriate, and governing comparator leading to the conclusion that the ATBs in each year of the collective agreement should be no less than 2 percent. ONA also points to a nursing shortage in Ontario demonstrated by enormous numbers of vacancies. It concludes from the data that there are an extremely large number of ongoing vacancies in the Participating Hospitals, while the increasing use of overtime and agency nurses is a symptom of this pervasive problem. Difficulties in recruitment and retention justify, in ONA's view, additional compensation increases, at the very least, ATB and/or the introduction of a new step on the grid.

On the other hand, the OHA sees things differently and points to an overall commonality in ATB outcomes over a prolonged period of time in the hospital sector with the other regulated professionals. It rejects any assertion of difficulties in recruitment and retention asserting that the ONA numbers are exaggerated and those that do exist are, in any event, almost entirely explained by the posting process. It points to an increase in new RNs far outstripping RN hospital resignations of senior nurses, which it says, in any event, are on the decline. There is, in the OHA's view, and simply stated, no recruitment or retention issue to be addressed and no case for additional compensation beyond sector norms – norms which it insists are determinative.

Having carefully reviewed the detailed submissions of the parties, we must conclude that there is a governing pattern in Central Hospital settlements and awards, and while it might be appropriate in some circumstances to depart from it – in cases of demonstrated need backed by compelling and convincing evidence – this is not one such case.

Of all the criteria considered by interest arbitrators, replication of free collective bargaining has primacy. This criterion is not, of course, chiseled in granite, and in appropriate cases freely negotiated settlements may not be followed – but when that happens there must be persuasive reasons to depart from free collective bargaining outcomes of relevant comparators, especially when there is a longstanding relationship of wage parity outcomes. There are departures, of course, but the pattern is

overwhelming. A few further observations are in order. In one of the examples relied on by the Association, the adjustment to the start rate awarded by Arbitrator Albertyn for the 2016 agreement, it is well-known that it had nothing to do with either recruitment or retention. In the two other examples, there was a general consensus and overwhelming and largely un-contradicted evidence – currently absent – about difficulties in recruitment and retention. In all of the other rounds, ATB outcomes were, more or less, the same.

In other words, replication is the default subject to context. And the context in this case is directly relevant comparator settlement of other Central Hospital professionals. Moreover, we cannot conclude on the data that was put before us that the Participating Hospitals are facing recruitment and retention challenges that would be best met through a compensation increase, and/or introduction of a new step. This would be essential in order to justify deviation from established norms. We do note, however, that there is definitely reason to be concerned about excessive overtime and the reliance on agency nurses at some hospitals. Likewise, there may be a vacancy issue at some hospitals. However, it does not appear system wide as is illustrated in the chart set out in the Association nominee's dissent where the data presented points to outliers not norms. Nevertheless, vacancies, overtime and use of agency nurses are important issues that, self-evidently, must be investigated and, depending on the results, appropriately addressed. At the very least, vacancies need to be filled and excessive overtime expenditure and reliance on agency nurses appears inconsistent with both best practices

for patient care not to mention the allocation of scarce health care economic resources. But for an interest arbitration board to deviate from replication in a central agreement covering virtually every hospital in the province demonstrated need backed by convincing evidence is self-evidently required.

Accordingly, the collective agreement settled by this award shall consist of the un-amended terms of the expired collective agreement, the agreed upon items and the terms of this award. Any outstanding Association and OHA issue not addressed in this award is dismissed.

Term

As agreed by the parties: April 1, 2018 – March 31, 2020

Across the Board

April 1, 2018: 1.4%

April 1, 2019: 1.75%

Retroactive compensation to all current and former employees within sixty days following issue of award.

Article 10.12

Add (e) A complete list of positions that have been vacated will be provided to the Union on a monthly basis.

Article 12.05

Amend final sentence as follows: For this reason, the time limit for referring such a grievance to arbitration will be extended for up to thirty-six (36) calendar days after the result is known to the Union.

Article 17

Add, effective sixty days following issue of award: Coverage for mental health services by a Psychologist, Registered Psychotherapist or Social Worker (MSW) for a total of $800 annually. Superior conditions maintained.

Pregnancy & Parental Leave

OHA proposal awarded effective date of award.

Vacation

Association proposal re: Paramedics awarded effective date of award.

Conclusion

At the request of the parties, we remain seized with respect to the implementation of our award.

DATED at Toronto this 31st day of July 2018.

"William Kaplan"

William Kaplan, Chair

I dissent. Dissent attached.

Brian O'Byrne, OHA Nominee

I dissent. Dissent attached.

Kate Hughes, Association Nominee

DISSENT OF OHA NOMINEE

I have read the Chair's award and while I agree with the wage increases he awarded as well as the pregnancy and parental leave clause he awarded, I find myself in disagreement with a number of other items he awarded and I am in complete disagreement with his failure to deal with two specific proposals of the hospitals which I will discuss below.

First of all, I wish to comment on the wage increases that were awarded. In my view, the award of 1.4% in 2018 and 1.75% in 2019 was the only possible interest arbitration outcome. As was pointed out by the Chair, replication is the primary factor that interest arbitrators take into account in fashioning an award. The hospital workforce is generally divided between professional and non-professional bargaining units. For many years now, the two major professional bargaining units that bargain centrally (i.e. ONA and OPSEU) have achieved the same general wage increases. OPSEU achieved wage increases of 1.4% in 2018 and 1.75% in 2019 through free collective central bargaining. Without a doubt, that was the logical and compelling comparator.

ONA attempted to steer the Board away from that comparator by asserting that, in their view, there were at least 10,000 ongoing RN vacancies in the Participating Hospitals (and a vacancy rate in excess of 10%) which, in turn, demonstrated, in their view, that those hospitals were experiencing very significant recruitment and retention problems and that additional compensation increases -- either across the board or through the introduction of new steps on the grid -- were necessary and justified in the circumstances.

The Participating Hospitals categorically denied all of those assertions and provided us with detailed, comprehensive data that supported their position.

The Board was therefore faced with having to make a decision as to whether ONA's assertions were borne out. The Chair, in my view, rightly concluded that the data put before us did not support ONA's assertions. In my view, the assertion that there were 10,000 ongoing vacancies at the Participating Hospitals (and a vacancy rate in excess of 10%) and therefore very significant recruitment and retention issues being experienced, was, and is, absurd.

I say this for a few reasons:

1. There are three types of vacancies under the ONA Central Collective Agreement - permanent full-time vacancies; permanent part-time vacancies and temporary vacancies.

   A permanent full-time or part-time vacancy can arise when an employee retires or resigns or when a new position is added to the bargaining unit. Due to the unusual definition of layoff in the collective agreement, vacancies can also arise through the merging of nursing units, which requires the elimination of existing positions and layoff of the incumbents, followed by the posting of the "new" positions in the merged unit.

Temporary vacancies are those arising out of a leave of absence or the creation of a new position not expected to exceed 60 days.

When a permanent vacancy arises in the bargaining unit, the vacancy must be posted for seven days. Only after the seven-day period can the scheduling and conducting of interviews, reviewing of results and selection of the successful applicant occur. Because of this, every permanent vacancy persists for more than a week, regardless of the number of qualified and interested candidates there are for the position. For this reason alone, relying on the absolute number of vacancies as an indicator of recruitment or retention concerns is inappropriate.

Where a permanent vacancy is filled with an internal applicant, the resulting vacancy must also be posted for seven days. The same process continues where each vacancy is filled with an internal applicant. The effect of this is to create multiple vacancies any time an employee retires or resigns or a new position is added to the bargaining unit. This movement of existing employees via the job posting process results in an inflated vacancy count relative to the actual number of departures or the introduction of new bargaining unit positions, further compromising the utility of vacancy numbers as an indicator of recruitment or retention concerns.

Further to these concerns regarding permanent vacancies, the inclusion of temporary vacancies in the vacancy count is also problematic. Under the collective agreement, temporary vacancies are those that arise out of a leave of absence or a new position being created which is otherwise not expected to exceed 60 days. The collective agreement requires that in the filling of temporary vacancies, consideration must first be given to existing part-time employees. The overwhelming majority of temporary vacancies under this collective agreement are due to leaves of absence given the extremely short duration assigned to temporary vacancies not arising from a leave of absence. As these temporary vacancies have permanent incumbents, the inclusion of temporary vacancies artificially inflates the existing number of vacancies.

2. The data regarding the number of vacancies (and the vacancy rate) at various Participating Hospitals that ONA provided to the Board was largely based on “assumptions” and “extrapolations”. That data was challenged by the Participating Hospitals on a number of grounds including, omissions of hospital reported data, double counting of data, and the characterization of annual data as “point in time” data among other issues. In contrast, the Participating Hospitals’ data indicated that the number of vacancies was substantially less than the number asserted by ONA. In terms of the vacancy rate, the Participating Hospitals’ data showed a figure of 3.8% which was less than the 3.9% vacancy rate for clinical professionals (a group that includes pharmacists, social workers, dieticians, physiotherapists, occupational therapists and others) and the same as the 3.8% vacancy rate for service workers. When all of this was taken into account, the Participating Hospitals were able to demonstrate that there had been a

massive overstatement in the number of vacancies reported by ONA as well as in the vacancy rate asserted by ONA.

3. Beyond the vacancy data provided by the parties – which for reasons stated above is of limited value in determining the existence of recruitment and retention issues – other data (including data published by the College of Nurses of Ontario and the Canadian Institute for Health Information) submitted by the Participating Hospitals debunked the assertion that the Participating Hospitals are having recruitment and retention problems. In no case, therefore, could the claim be convincingly made that there was **ANY** issue with respect to recruitment and retention.

4. Ultimately, while the 10,000 figure is catchy, upon careful examination it is unsupported by any reliable underlying data. Indeed, the data completely refutes the 10,000 number which was extremely misleading. The Chair was correct in giving it no weight.

As for the other items awarded by the Chair, while I do not agree with everything he awarded, I will just comment on one item, namely, his award of mental health services coverage. Many hospitals already provided some form of coverage through their extended health care plan. The Chair has now significantly increased the coverage provided which, in my view, was not justified at all. None of the other hospital unions have achieved such coverage in their collective agreements and the ONA extended health care plan is already superior. Hence, I do not feel that the award of increased coverage is justified.

Finally, I want to touch on two proposals made by the Participating Hospitals which were not awarded and which, in my view, should have been awarded.

The first proposal was to add the words "where a nurse would otherwise be laid off as a result of a permanent reduction in her or his hours of work" at the start of Article 10.14(b). This is the article that provides for offers of retirement allowances in situations where there is going to be a long-term layoff on a unit. This article first came into the collective agreement in 1996. Back then, ONA had proposed the introduction of offers of retirement allowance in advance of long-term layoffs in order to provide more options to nurses who would otherwise have lost their jobs through downsizing and restructuring initiatives. Back at that time, the current expansive definition of layoff had not been established. It was not until a series of rights arbitration awards between 2003 and 2012 which eventually established that a reassignment of a nurse for more than a single shift constitutes a layoff, and therefore, a reassignment for longer than three months constituted a long-term layoff. As the definition of long-term layoff changed, offers of retirement allowance became triggered in situations not originally envisaged when they were first introduced into the collective agreement. These offers were designed to mitigate the impact of layoffs by incenting nurses to leave the hospital voluntarily in order to avoid involuntary job loss resulting from a reduction of nursing staff complement. Now, offers are also triggered in circumstances where the hospital is not seeking to reduce the nursing staff complement, but instead to simply reorganize their operations and realign the existing workforce. The proposal of the Hospitals would restore the original intent for having retirement allowances. It does not seek to amend the definition of layoff. The proposal simply seeks to end the offer and payment of

retirement allowances in circumstances where a layoff is not triggered. That makes absolute sense. Why should nurses be incented to leave the hospital and take a retirement allowance where no one is being laid off? I would have awarded the proposal.

The second proposal of the Participating Hospitals was to amend the Temporary Vacancy definition in Article 10.07(d) by adding "projects not expected to exceed twenty-four months".

We were told that hospitals are required to continually innovate to find more effective and efficient ways to deliver quality patient care or to handle ongoing capacity challenges. Sometimes, this means trialing a new position or instituting a time-limited project to help change care delivery models or methods. Furthermore, from time to time, funding for projects is granted to hospitals separate and apart from general operating funding they receive and is usually time-limited. Under the current language of the Agreement, if these trials or projects last longer than sixty days, then the position must be posted as a permanent position and filled in accordance with the job posting provisions under Article 10.07(a). Then, when that position is discontinued, the layoff provisions of the collective agreement are triggered.

The Hospitals cited a number of examples of situations where the strict language of the current clause has been enforced and the problems such an approach has caused for hospitals. As the Hospitals pointed out in their brief: "the requirement to post temporary positions attached to time limited projects is extremely problematic for hospitals, as it creates unnecessary barriers to the Participating Hospitals' desire to innovate, improve patient care and/or address capacity issues". Under the current situation, hospitals will be rightly hesitant to establish projects or accept external time-limited funding, knowing that it will have to bear the cost of laying off the incumbents in these temporary positions, including the potential cost of paying retirement allowances (which I discussed above). This means that the hospital will lose out on the opportunity to engage special funding; the community loses out on the opportunity to have the special project or service provided at their hospital and the nurses lose out on the opportunity to expand their skills and knowledge by working on a new initiative. This was a very meritorious proposal and I would have awarded it.

ALL OF WHICH IS RESPECTFULLY SUBMITTED

July 6, 2018

"Brian O'Byrne"
Brian O'Byrne

IN THE MATTER OF AN INTEREST ARBITRATION

BETWEEN:

THE PARTICIPATING HOSPITALS

- and –

ONTARIO NURSES' ASSOCIATION

DISSENT OF THE UNION NOMINEE

Having reviewed the award of the Chair, I must regrettably dissent on almost all issues. The award is wholly inadequate. After a lengthy interest arbitration process that included, between the parties, 133 exhibits and over twenty proposals, the short decision by the Chair – dealing with only a small fraction of the issues raised by the parties – is disappointing to say the least.

Though there are a multitude of problems in the Ontario hospital sector that this Award could have helped the parties address, almost all of them are ignored in this Award. To quote the OHA submission, Ontario hospitals are presently facing an "unprecedented and dangerous capacity problem"; ONA and OHA both provided the Board with evidence of "overcrowded hospitals" and the "crisis" of "hallway" nursing.

In fact, the Board heard that the situation was so dire that Anthony Dale, President of the OHA, wrote a letter to the Premier of the province setting out, in depth, the crisis capacity problem across the province. As he noted: "Occupancy in many hospitals has exceeded 100 percent over the past 6 months, and in some cases, it reached as high as 140 percent".

A lack of capacity means, to a large extent, a lack of Registered Nurses. Hospitals working over capacity, with inadequate staffing and funding, means that the increased workload falls on the existing staff: the Registered Nurses who perform "hallway" nursing and deal with a constant "surge" of patients in hospitals that run well over the capacity for which they were designed and are staffed to run.

The Board heard evidence from both parties regarding the large amount of overtime expenditures that are spent by Ontario hospitals. The disclosure from the OHA, for the base year expiring March 31, 2018 of November 15, 2017, for example, states that 131 hospitals had spent $128,566,201 in staffing at overtime rates rather than regular time (for 131 hospitals as some hospitals reported together). This huge amount of overtime is an indication of the lack of Nurses available for work at straight time.

In addition, hospital vacancy rates provide evidence of the shortage of nurses and the problems that many Participating Hospitals are facing with respect to the recruitment and retention of Registered Nurses. With respect to an exact number of vacancies, it was difficult for ONA, and hence the Board, to determine with precision the specific vacancy rate. This is due to the fact that not all Participating Hospitals responded to the disclosure order of the Board requiring them to provide this information. ONA reported receiving responses for 63 hospitals, which is less than 50% of the Participating Hospitals. Furthermore, those hospitals that responded did so inconsistently i.e. some provided current posted positions; some provided positions that were posted and not filled; and, others provided all postings for the relevant time period. The OHA disputes this and claims that another 15 hospitals had responded before the Board's order but agrees that the information in the reports were not consistently given by the hospitals. The fact remains that there was inadequate and inconsistent disclosure by the hospitals.

What the hospitals did disclose, however, indicates and supports ONA's position that there are significant vacancies across the province, even with OHA's recalculations. Nitpicking about the specific numbers does not hide the fact that there was demonstrable evidence of a problematic shortage of Registered Nurses. While the OHA tried to minimize the vacancies and criticize ONA for extrapolating based on the inadequate disclosure, even with the OHA manipulation of the vacancy numbers the vacancies are a concern.

For instance, the OHA provided a chart, which set out data from 16 of the over 130 Participating Hospitals (reproduced below). The OHA refers to this as "point in time data". It indicates 946 vacancies—a significant number for any "point in time" for 16 hospitals.

Hospital	**Actual Point in Time Vacancies**				
	Permanent		**Temporary**		
	FT	PT	FT	PT	**Total**
Alexandra Marine & General	0	1	1	1	3
Campbellford Memorial Hospital	0	6	0	4	10
Centre for Addiction and Mental Health	5	24	12	2	43
Collingwood General & Marine	0	3	1	2	6
Grey Bruce Health Services	8	10	3	2	23
Hamilton Health Sciences	63	150	41	69	323
Joseph Brant Hospital	26	6	4	9	45
Lakeridge Health Corporation	46	69	21	16	152
Manitoulin Health Centre	0	2	0	0	2
Peterborough Regional Health Centre	10	34	9	16	69
Royal Ottawa Health Care Group	14	17	0	0	31
Scarborough & Rouge Hospital – RVHS	8	33	0	0	41
Scarborough & Rouge Hospital – TSH	12	42	0	0	54
St. Mary's General Hospital	3	9	4	0	16
St. Thomas Elgin General Hospital	0	13	0	0	13

Trillium Health Partners	44	41	16	7	108
West Haldimand General Hospital	0	7	0	0	7
Total	**239**	**467**	**112**	**128**	**946**

The widespread use of nursing agencies to supply Registered Nurses to hospitals is a further indication of the inability to recruit and retain Registered Nurses in Ontario. Many Ontario hospitals are regularly using and paying high costs and penalties for the use of agency Registered Nurses to supplement their staff due to staffing shortages. There have been numerous grievances and arbitrations with Participating Hospitals regarding the high use of agency nurses in response to this practice. The position of individual Hospitals in such grievances is that they cannot comply with the collective agreement's requirement, in article 10.12 (c) of the Central Agreement, to make "ongoing best efforts to reduce any use of agency Nurses," because they cannot recruit or retain enough trained Registered Nurses on staff.

The Board also heard troubling evidence that there is a widespread practice across the Participating Hospitals of not filling shifts when there are gaps in staffing (*i.e.* they do not schedule a replacement for a Nurse who calls in sick or is on a scheduled vacation or leave). This was not mere anecdotal evidence, the Board was given numerous exhibits of staffing schedules confirming the practice, from a variety of the Participating Hospitals.

Numerous Professional Responsibility Reports were also entered as exhibits, which demonstrate the repeat complaints filed by Registered Nurses that they cannot meet their professional standards due to understaffing, workload problems and use of agency nurses at their respective hospital. Exhibits were also provided of "Independent Assessment Committee" (IAC) reports, which also indicate that the shortage of Registered Nurses has resulted in Professional Responsibility Complaints. The IAC reports cite chronic staffing shortages, agency use, and high overtime as major issues throughout the sector.

Indeed, as one IAC hearing report from October 2017 documented the Participating Hospital in issue admitted that it did not have sufficient baseline Registered Nurse staffing and the Report had 28 recommendations in a number of relevant areas for this Board, indicating significant recruitment and retention difficulties for staffing Registered Nurses. In another hospital, we were provided evidence of 150 Professional Responsibility Reports that have been filed since January 2015 at that hospital alone. This was not disputed by the OHA.

Agency use, ongoing vacancies, high overtime, the increasing number of untenable workload complaints, increasing patient volumes and patient "surges", hospitals running over capacity on an increasing basis (such that it is called a "crisis" by the OHA) – these are all evidence of a demonstrable need for many of ONA's proposals. Taking an ostrich approach helps neither party and does not help the health care system deal with current realities and the need for highly skilled Registered Nurses.

The Chair's award, with one exception, did nothing to *attract* Registered Nurses to come to hospital nursing in Ontario, or to *remain* in hospital nursing in Ontario.

First of all, the overall compensation package is grossly inadequate. An increase of 1.4% and 1.75% on the grid will not even keep nursing salaries in line with inflation, which the Board heard in evidence from both parties is well in excess of 2%. Accordingly, these important front-line professionals – who are dealing with increasingly untenable workloads due to Hospitals running over capacity, increasing acuity, and the growing and aging population in Ontario – will see their salaries eroded below the undisputed rising cost of living. The Chair gave these Health Professionals, in effect, a cut in pay.

The Chair claims he must conclude there is a governing pattern in Central Hospital settlements and awards and therefore must follow the most recent settlement with another union, a union that does not represent Registered Nurses. I disagree with this conclusion. As many arbitrators have commented, the role of an Interest Arbitration Board is to apply the statutory criteria and other considerations in attempting to duplicate what the parties themselves would have achieved in bargaining. ONA should not be high-jacked by the bargaining that has been done, or not done, by another union.

I do agree with the Chair that the replication principle is subject to context; however, rather than a "'governing pattern," the settlement he followed was a mere reopener on wages with virtually nothing else, other than a concession on pregnancy leave. The replication principle should not dictate that another union should be constrained by this unusual settlement done in mid-collective agreement term. A "one off" reopener by one union, which dealt only with a continuation of its previous years' wages with little else and with no review of the present evidence relevant to Registered Nurses, should not dictate a Central Award for Registered Nurses.

There is no indication that the parties, namely ONA, would have bargained this agreement in free bargaining. A review of ONA's bargaining history with OHA, which is a history of 16 previous rounds, does not indicate that ONA would have ever bargained in this way. *HLDAA* takes away a union's right to strike; it does not dictate a blind following of the first agreement reached right out of the gate.

ONA has freely negotiated gains of 2% increases for Registered Nurses in Community Care Access Centres (now Local Health Integration Networks) and in Nursing Homes. A review of teachers, police, fire services, colleges and the Broader Public Sector in Ontario indicates a trend of similar 'across the board' 2% increases. There is no reason why Registered Nurses – the professionals who deal with the most acute care needs in our overcapacity hospitals – should be provided with less than 2%.

In addition, Registered Nurses should have an additional step placed on their wage grid. Currently there is no step following the eight-year rate until the 25-year rate is reached. This gap of 17 years is far too long, and it would serve as an additional incentive towards retaining Registered Nurses to bridge this gap. While it may be a small incentive in this climate of hospitals struggling with patient surges, an aging and growing population, and underfunding, it is crucial that Ontario hospitals take all possible measures to provide incentives to senior and experienced nurses to remain in the hospital.

We were provided with evidence that ONA has had a very different practice of bargaining history with many changes to its grid with a different history that of the “comparable” union that the Chair follows. In fact, 44% of the ONA collective agreements contain adjustments to the wage grid, in addition to

'across the board' increases. For example, the Keller Award from April 1, 2004 to March 31, 2006 added the 25-year rate. The Albertyn Award in 2007 adjusted the start rate of three steps on the grid – well above the 'across the board' percentage increase. The Albertyn Award from April 1, 2016 to March 31, 2017 provided an extra adjustment of 32 cents to the first step, in addition to the 'across the board' increase on all steps.

This history is not replicated by other unions in the hospital sector, who received none of these improvements in the similar rounds of bargaining. It is one of many examples which demonstrate that there is no strict governing pattern in the Central Hospital settlements and Awards with other unions in the sector who do not represent Registered Nurses. While there are of course similarities, there are many difference with no history of simple replication with other unions' settlements and awards. I would have awarded the additional step at 15 years, to address the aforementioned situation between these parties and their history of grid step adjustments.

Improvements should have also been made in other areas, in particular with respect to shift premiums. There is a considerable history of ONA negotiating or having been awarded, in most rounds, an increase in premiums for evening, night, and weekend shifts at the same time as wage increases. The evidence establishes that, in bargaining, these parties have historically looked to nursing rates and premiums across the country. Other provincial health care employers are the labour market competitors for this limited and important group of professionals. While at one time Ontario may have led the other provinces, it has unfortunately and inexplicably since slipped in the rankings.

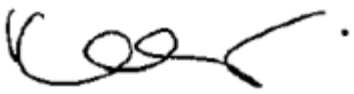
As a result, Ontario has fallen firmly behind other provinces in respect of these premiums that are paid to nurses on evening, nights, and weekends. For example, the evening premium paid to nurses in Saskatchewan and Alberta is higher than Ontario by $1.25 and $0.50 an hour, respectively, with similar Ontario shortfalls on weekend premiums. The differences are even higher on night shifts. Accordingly, as is the norm with these parties, I would have awarded an increase in the premiums.

With respect to health and welfare benefits, while I applaud the Chair for adding much needed benefits for mental health services, the rest of the health and welfare proposals were ignored. In particular, I would have awarded the increase sought by the union for vision care as $100.00 per year. The Board had evidence before it that the current market costs for eye glasses are well above what is currently provided for in the plan, thus demonstrating the need for an increase. The cost of glasses, particularly for the senior nurses that Hospitals need to retain, is considerable and even more costly for bifocal and trifocal lenses that are needed as the workforce ages. Moreover, as hospitals have become increasingly computerized, there is the added costs of anti-reflective coatings, which are needed to prevent the eye strain that results from prolonged exposure to computer screens.

ONA also sought to remedy the inconsistencies between hospitals in respect of the wages paid to Nurse Practitioners. The Board has declined to intervene in this regard. It is hoped that in the future the parties can determine a process by which it can ensure an equity of wages for these groups such that these the disparities in wages for Nurse Practitioners do not continue.

Most troubling is that the Award also ignores important proposals regarding language changes, particularly language to address the workload problems for which we heard considerable evidence about, as described above. ONA, for instance, sought language clarification to Article 10.07 to ensure that short term vacancies caused by illness, accidents, and leaves of absences such as pregnancy and parental leave, shall be filled by a Nurse within the same classification. To support this proposal, the Board was provided with evidence detailing a widespread practice among Participating Hospitals, such as the schedules found at Exhibits 63-68, in which RNs are being replaced with RPNs. As a result, many hospital units are limping along with staffing that is well below the planned RN staffing levels. This is simply dangerous given the different scopes of practice that exist for Registered Nurses and Registered Practical Nurses in acute care settings. It is particularly dangerous in the crisis situation that was described by the OHA itself, whereby surges and overcapacity situations have now become the new norm.

Numerous grievances regarding Professional Responsibility Reports and the inappropriate use of Registered Practical Nurses in place of the use of Registered Nurses have been filed across the province. This Board could have assisted the parties in providing clarification in the collective agreement language to avoid such disputes about the use of Registered Practical Nurses and workload matters. It failed to do so in this Award, which is a disappointment.



Kate Hughes, Union Nominee

July 17, 2018